

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1604</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/17/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANCHESTER HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>395 INTERSTATE DRIVE MANCHESTER, TN 37355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During complaint investigation of TN00040593 conducted on 2/17/2017, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE